

EXHIBIT J



Nationwide®
On Your Side

Argiris Michael Niamonito
7282 Leonard Street
Philadelphia, PA 19149

Your Policy Renewal

Your bill is sent separately.

Nationwide Auto Policy

Policy Period: Aug 29, 2015 - Feb 29, 2016

Policy Number: **5837E 925160**

Sign up for convenient,
automatic bill payment
with Nationwide Easy Pay.
To learn more, ask your
agent or log in to
nationwide.com/easypay.

Hermine Byfield
9200 Bustleton Ave
Apt 405
Philadelphia, PA
19115-4218

What's enclosed

- ✓ **Insurance Identification Cards** - Your ID cards are enclosed in this packet.
- ✓ **Declarations** - These pages show **your coverages** under this policy. Carefully review these details and call **Argiris Michael Niamonito at 215.338.7331** if you have questions or want to make changes.
 - **General Information**
 - **Coverage Details**
 - **Your Total Policy Premium**
- ✓ **Insurance Documents** - Please keep these documents for future reference.

How to Contact Us

Your Nationwide Agent
Customer Service
Internet
24-Hour Claims Reporting
Hearing Impaired (TTY)

Argiris Michael Niamonito 215.338.7331
1.877.669.6877
Nationwide.com
1.800.421.3535
1.800.622.2421



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Important Reminders from Nationwide

NOTES:

Mandated Coverage Notice:

The laws of the Commonwealth of Pennsylvania, as enacted by the General Assembly, only require that you purchase Liability and First Party Medical Benefit coverages. Any additional coverage or coverages in excess of the limits required by law are provided only at your request as enhancements to basic coverages.

Premiums For Basic Mandatory Coverage At The Limited Tort Option:

Vehicle #1: 2008 Nissan Maxima S

Vehicle #2: 2014 Nissan Rogue S/

Coverage	Limits	Premiums	Coverage	Limits	Premiums
Bodily Injury Liability	\$ 15,000 \$ 30,000	\$ [REDACTED]	Bodily Injury Liability	\$ 15,000 \$ 30,000	\$ [REDACTED]
Property Damage Liability	\$ 5,000	\$ [REDACTED]	Property Damage Liability	\$ 5,000	\$ [REDACTED]
Medical Benefits	\$ 5,000	\$ [REDACTED]	Medical Benefits	\$ 5,000	\$ [REDACTED]

Fraud Warning Notice

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Your premium for this renewal is \$ [REDACTED]. To maintain uninterrupted coverage, please pay your premium by the due date on the bill. This includes any change you may have made to your policy.

Thanks to five years of safe driving you're receiving the Accident Free discount.

Your credit report will only be ordered at the start of your policy with Nationwide unless you request an update. You may request a new credit-based insurance score once each year to be used to rate your policy. To request an updated insurance score, please contact us at 1-877-302-1833.

Sign up for convenient, automatic bill payment with Nationwide Easy Pay. To learn more, ask your agent or log in to nationwide.com/easypay.

Manage your account, make a payment, check the status of a claim and receive your bill by email with online Account Access. Visit nationwide.com/manage - see how easy it can be.

Nationwide thanks you for your business. Our first priority is to serve you, our Customer.

Whether you have a claim, a question, a concern, or just need a convenient service, our *On Your Side* promise means we'll be there to serve your needs.

Thank you for choosing Nationwide. We value your business.





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Your Policy Declarations

Nationwide Auto Policy

Policy Period: Aug 29, 2015 - Feb 29, 2016

Policy Number: **5837E 925160**

Policyholder (Named Insured):

Hermine Byfield
9200 Bustleton Ave
Apt 405
Philadelphia, PA
19115-4218

Keep these Declarations for your records.

General Policy Information

Issued: August 5, 2015

These Declarations are a part of the policy named above and identified by the policy number above. They supersede any Declarations issued earlier. Your policy provides the coverages and limits shown in the schedule of coverages. They apply to each insured vehicle as indicated. Your policy complies with the motorists' financial responsibility laws of your state only for vehicles for which Property Damage and Bodily Injury Liability coverages are provided.

Policy Period: August 29, 2015 - February 29, 2016 but only if the required premium for this period has been paid and only for six month renewal periods if renewal premiums have been paid as required. This policy is initially effective at (1) the time the application for insurance is completed, or (2) 12:01 a.m. on the first day of the policy period, whichever is later. Each renewal period begins and ends at 12:01 a.m. standard time at the address of the named insured stated herein. This policy expires at 12:01 a.m. at the address of the named insured stated herein.

Your carrier is Nationwide Property And Casualty Insurance Company, NAIC #37877.

IMPORTANT MESSAGES:

IF THIS DECLARATIONS PAGE SHOWS THAT COLLISION COVERAGE APPLIES TO YOUR AUTO, THERE IS ALSO COLLISION COVERAGE FOR DAMAGE TO A RENTED AUTO. COVERAGE IS SUBJECT TO CONDITIONS AND LIMITATIONS LISTED IN THE POLICY OR ATTACHED ENDORSEMENTS.

Changes Made to Your Policy

- **Effective August 29, 2015**
- 2008 Niss Maxima S
- Changed Property Damage Liability
- 2014 Niss Rogue S/
- Changed Property Damage Liability

Premium Summary and Other Charges

2008 Nissan Maxima S	\$	
2014 Nissan Rogue S/	\$	
Total For Policy Coverages	\$	
Total Policy Premium		\$

How You Saved on this Policy with Nationwide

- Passive Restraint
- Anti Theft Device
- Multi Line
- New Vehicle
- Accident Free
- Multi Car
- Affinity
- Paperless Policy
- Safe Driver
- Home & Car
- Advance Quote
- Farm Bureau Member



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Your Policy Declarations

Nationwide Auto Policy

Policy Period: Aug 29, 2015 - Feb 29, 2016

Policy Number: **5837E 925160**

For coverage definitions and descriptions,
visit Nationwide.com

Listed Driver(s)

Name	Date of Birth	Marital Status
Hermine Byfield		Single
Samantha Carroll		Single

Insured Vehicle(s) and Schedule of Coverages

2008 Nissan Maxima S

VIN 1N4BA41E68C838945

Coverages	Limits of Liability	Premium
Comprehensive and \$ 1,500 IN Customization	Actual Cash Value Less \$ 250	\$
Collision and \$ 1,500 IN Customization	Actual Cash Value Less \$ 500	\$
Property Damage Liability	\$ 25,000 Each Occurrence	\$
Bodily Injury Liability	\$ 15,000 Each Person	\$
	\$ 30,000 Each Occurrence	\$
Uninsured Motorists-Bodily Injury	(Non-Stacked)	
	\$ 15,000 Each Person	\$
	\$ 30,000 Each Occurrence	\$
Underinsured Motorists-Bodily Injury	(Non-Stacked)	
	\$ 15,000 Each Person	\$
	\$ 30,000 Each Occurrence	\$
Loss Of Use-Rental Days Plus	Endorsement 3573	\$
	\$ 30 Per Day	
	\$ 900 Per Accident	
First Party Benefits		
Option 1-Medical Benefit	\$ 5,000	\$
Option 4-Funeral Benefit	\$ 2,500	\$
Full Tort		
Total for this Vehicle		\$

2014 Nissan Rogue S/

VIN 5N1AT2MV6EC808478

Coverages	Limits of Liability	Premium
Comprehensive and \$ 1,500 IN Customization	Actual Cash Value Less \$ 250	\$
Collision and \$ 1,500 IN Customization	Actual Cash Value Less \$ 500	\$
Property Damage Liability	\$ 25,000 Each Occurrence	\$
Bodily Injury Liability	\$ 15,000 Each Person	\$
	\$ 30,000 Each Occurrence	\$
Uninsured Motorists-Bodily Injury	(Non-Stacked)	
	\$ 15,000 Each Person	\$
	\$ 30,000 Each Occurrence	\$
Underinsured Motorists-Bodily Injury	(Non-Stacked)	

Continued on the next page

**Nationwide®**
On Your Side**Your Policy Declarations****Nationwide Auto Policy**

Policy Period: Aug 29, 2015 - Feb 29, 2016

Policy Number: **5837E 925160****Insured Vehicle(s) and Schedule of Coverages (continued)****2014 Nissan Rogue S/**

VIN 5N1AT2MV6EC808478

Coverages	Limits of Liability	Premium
	\$ 15,000 Each Person	
	\$ 30,000 Each Occurrence	\$
Loss Of Use-Rental Days Plus	Endorsement 3573	\$
	\$ 30 Per Day	
	\$ 900 Per Accident	
First Party Benefits		
Option 1-Medical Benefit	\$ 5,000	\$
Option 4-Funeral Benefit	\$ 2,500	\$
Full Tort		
Lienholder-Citadel FCU	Lien Expires On Apr 08, 2021	
Total for this Vehicle		\$

Policy Level Schedule of Coverages

Coverages	Limits of Liability	Premium
Roadside Assistance	Plus - Covers Disablement Up To 100 Miles/\$100 Lockout/ \$ 500 Trip Interruption Endorsement 3436	\$
Accident Forgiveness Feature - Accident Currently Forgiven		
Total for Policy Coverages		\$

Policy Form and Endorsements

Z-037 Nationwide Auto Policy
V-3436 Roadside Assistance Coverage
V-3573 Loss of Use - Rental Days Plus

For Office Use Only:

04/20/15 \$ 0.00

Issued By: Nationwide Property And Casualty Insurance Company**Countersigned At:** Harrisburg, PA.**By:** Gregory C Ott LUTCF**How to Contact Us**

Your Nationwide Agent
Customer Service
Internet
24-Hour Claims Reporting
Hearing Impaired (TTY)

Argiris Michael Niamonito 215.338.7331
1.877.669.6877
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Your Policy Declarations

Nationwide Auto Policy

Policy Period: Aug 29, 2015 - Feb 29, 2016

Policy Number: **5837E 925160**





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First Party Benefits

Coverage agreement

This coverage provides First Party Benefit options in accordance with the Pennsylvania Motor Vehicle Financial Responsibility Law. The options and limits which the **policyholder** has selected are shown in the Declarations.

We will pay First Party Benefits for the **bodily injury** of an **insured** as a result of an accident that arises out of the maintenance or use of a **motor vehicle** as a **motor vehicle**. **We** will pay these benefits regardless of who is at fault in the accident.

Additional definitions applicable to this coverage

For purposes of this coverage only:

"NECESSARY MEDICAL TREATMENT AND REHABILITATIVE SERVICES" means:

1. treatment;
2. accommodations; and
3. products or services;

which are determined to be necessary by a licensed health care provider unless they shall have been found or determined to be unnecessary by a state-approved Peer Review Organization (PRO).

Insureds

The **policyholder** and **relatives** are covered while **occupying** or injured by any **motor vehicle**.

Persons other than the **policyholder** and **relatives** are covered:

- a) while **occupying your auto**.
- b) as non-occupants of a **motor vehicle** if injured as a result of an accident in Pennsylvania involving **your auto**.

Options

Option 1—Medical Benefit

We will pay all reasonable expenses for **necessary medical treatment and rehabilitative services**.

We will pay such expenses up to the limit shown on the Declarations.

Subject to the applicable provisions of the Motor Vehicle Responsibility Law concerning the statute of limitations, there is no time limitation for this benefit, provided that, within 18 months after the date of the accident, it is determined with reasonable medical probability that further expenses may be incurred as a result of the injury.

Option 2 - Income Loss Benefit

If this option is selected by payment of premium, **we** will pay for loss of income from work the **insured** was unable to do because of **bodily injury**. **We** will not pay under this benefit until five working days have been lost. **We** will not pay for these five days of lost income.

"LOSS OF INCOME" means:

- a) 80 percent of actual loss of gross income. Gross income is income received from work performed while normally employed in gainful activity.
- b) reasonable expenses actually incurred for hiring a substitute to perform self-employment services in order to reduce loss of gross income or for hiring special help which permits a person to work and reduce loss of gross income.

We will pay such benefits up to the limit shown on the Declarations. However, the total limit of this benefit is subject to the monthly maximum shown on the Declarations.

Income Loss Benefits do not continue after a person dies.

**Option 3—Accidental Death Benefit**

If this option is selected by payment of premium, **we** will pay the Accidental Death Benefit for the **policyholder** or a **relative** who suffers accidental **bodily injury** causing death from a covered accident. **We** will pay the Accidental Death Benefit limit shown in the Declarations. Death must occur within two years of, and as a direct result of, the accident. Payment will be made to the:

- a) executor; or
- b) administrator;

of the estate. In the alternative, payment will be made to the surviving spouse.

Option 4—Funeral Benefit

If this option is selected by payment of premium, **we** will pay reasonable expenses directly related to the:

- a) funeral;
- b) burial;
- c) cremation; or
- d) other form of disposition of the remains of a deceased **insured**.

These expenses must be the direct result of death from a covered accident within two years of the date of the accident. Payment will be made to any person presenting bills for qualified expenses incurred.

We will pay such expenses up to the limit shown on the Declarations.

Option 5—Combined Loss Benefits

If this option is selected by payment of premium, **we** will pay the benefits described in Options 1, 2, 3, and 4 above. However, total benefits payable under this option are limited to:

- a) the aggregate limit shown on the Declarations for this option; or
- b) three years from the date of the accident;

whichever occurs first.

Option 5 is subject to the following conditions:

- a) within 18 months after the date of the accident, it must be determined with reasonable medical probability that future medical expenses will be incurred as a result of the injury.
- b) in no event will benefits be paid beyond three years from the date of the accident.
- c) there is no monthly dollar maximum for Income Loss Benefits.
- d) the maximum Accidental Death Benefit payable is \$25,000.
- e) the maximum Funeral Benefit payable is \$2,500.
- f) benefits under d) and e) are only payable if death occurs within two years of the date of the accident.

Option 6—Excess Medical Benefits

If this option is selected by payment of premium, **we** will pay the Excess Medical Benefits for an **insured** who suffers accidental **bodily injury** from a covered accident. Excess Medical Benefits are reasonable expenses for **necessary medical treatment and rehabilitative services**. **We** will pay such expenses in excess of \$100,000 but not to exceed one million dollars. **We** will not pay Excess Medical Benefits to an **insured** who is not eligible for Option 1—Medical Benefits under this policy.

Our liability to one person in one accident is \$50,000 per year. Subject to this limit for any one person in any one year, **our** aggregate limit for any one person is one million dollars for any one accident. During the first 18 months of eligibility, **we** shall approve payments for an **insured** without regard to the \$50,000 per year limit. For purposes of this option, the first 18 months of eligibility begins when the **insured** has incurred \$100,000 of eligible **necessary medical treatment and rehabilitative services** expenses.



If the **insured** is covered by Option 5—Combined Loss Benefits package (or a similar auto benefits package with another insurer), applicable Medical Benefit limits greater than \$100,000 in such package shall be excess over any sums paid or payable under Excess Medical Benefits.

Coverage exclusions

We will not pay First Party Benefits in certain circumstances, as follows:

1. The **policyholder** and **relatives** are not covered for **bodily injury** arising out of the maintenance or use of a **motor vehicle** that the **policyholder** owns that is not an insured **motor vehicle**. An insured **motor vehicle** is one on which there are First Party Benefits and to which the Auto bodily injury liability coverage in this policy applies.
2. There is no coverage for **bodily injury** to a **relative** arising out of the maintenance or use of a **motor vehicle** owned by such **relative** which is not insured for First Party Benefits and Auto bodily injury liability coverage under this or any other policy.
3. There is no coverage for anyone while **occupying** a:
 - a) motorcycle;
 - b) motor-driven cycle;
 - c) motorized pedalcycle, or similar type vehicles; or
 - d) a recreational vehicle not intended for highway use.
4. There is no coverage for anyone, other than the **policyholder** or a **relative**, who knowingly converts a **motor vehicle**.
5. There is no coverage for anyone injured by **your auto** while it is unoccupied and parked so as not to cause unreasonable risk of injury.
6. There is no coverage for use of any **motor vehicle** by an **insured**:
 - a) to carry persons or property for a fee or compensation; or
 - b) on a regular basis for retail or wholesale delivery, including but not limited to pizza, magazine, newspaper and mail delivery.

Exclusion 6.a) does not apply to **motor vehicles** used in the shared-expense car pools.

7. There is no coverage for anyone who is the owner of a currently registered **motor vehicle** and who does not have financial responsibility. Financial responsibility means the type of financial responsibility that was self-certified to the Department of Transportation to obtain the registration.
8. **We** will not pay any benefits to or for anyone who injures themselves:
 - a) or another intentionally, including an attempt to intentionally injure themselves or another;
 - b) while committing a felony; or
 - c) while seeking to elude lawful apprehension or arrest by a law enforcement official.
9. There is no coverage for loss sustained by any person as a direct result of loading or unloading any **motor vehicle**, except while **occupying** the **motor vehicle**.
10. There is no coverage for **bodily injury** caused by or resulting from an act of war, including insurrection, rebellion or revolution.
11. There is no coverage for **bodily injury** caused by or resulting from:
 - a) nuclear hazard meaning any:
 - (1) nuclear reaction;
 - (2) nuclear discharge;
 - (3) radiation; or
 - (4) radioactive contamination;



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- b) discharge of a biological weapon resulting in biological contamination;
whether controlled or uncontrolled or however caused, or as a consequence of any of these.
12. There is no coverage for expenses, charges or costs arising directly or indirectly from **bodily injury** caused by or resulting from the inhalation of, ingestion of, contact with, exposure to, existence of or presence of any fungi, algae, lichens, slime, mold, bacteria, wet or dry rot and any scents or by-products of these organisms, however produced. Fungi as used above include, but are not limited to any type or form of fungus, yeasts, mold, mildew, mycotoxins, spores, rust, smuts or fleshy fungi such as mushrooms, puffballs and coral fungi.
13. There is no coverage for **bodily injury** arising out of the ownership, operation, maintenance or use of any **motor vehicle**:
- a) while used in an organized or prearranged competitive event, including but not limited to:
- (1) racing contest or event; or
 - (2) speed contest or event; or
 - (3) in practice or preparation for any racing or speed contest or event.
- b) while used in **performance testing** that is done on a closed road, or a race track, or a testing facility environment where the **insured** is not competing.
- Performance testing** is when an **insured** uses any **motor vehicle** to:
- (1) test its performance in speed, handling; or
 - (2) test or practice driver skills.
- Performance testing** does not apply to student-driver training activities an **insured** participates in to obtain that person's state issued learners permit or drivers license. **Performance testing** also does not apply to driver training activities an **insured** participates in to complete that person's state sanctioned courses in motor vehicle accident prevention, defensive driving, or driver improvement.
14. There is no coverage from the use of any **motor vehicle** which any **insured**:
- a) uses without a reasonable belief of being entitled to do so;
 - b) has stolen; or
 - c) knows to have been stolen.

An **insured** shall not be held to have a reasonable belief of being entitled to operate a **motor vehicle** if that person's license has been suspended, revoked, or never issued.

This exclusion does not apply to the use of **your auto** by:

- a) **you**;
- b) a **relative**; or
- c) a business partner, employee, or agent of **you** or a **relative**.

Limits and conditions of payment

Limits apply as stated in the attached Declarations. However, the insuring of more than one person or vehicle under this First Party Benefits coverage does not increase the limit of coverage to any one person in any one accident. In no event will any **insured** be entitled to more than the highest limit applicable to any one **motor vehicle** under this or any other policy. The following conditions apply to the relationship of this coverage to other insurance or benefits that may be available:

Priorities of policies

We will pay First Party Benefits in accordance with the order of priorities set forth by law. **We** will not pay if there is other insurance at a higher level of priority, even if the limits of that



insurance have been paid. The highest priority level listed below is the FIRST level which provides benefits for a named insured. The priority order is:

- FIRST—** For a named insured on any policy, the policy on which that person is the named insured.
- SECOND—** For a **relative**, the policy covering the **relative** as an **insured**.
- THIRD—** For the occupants of an insured **motor vehicle**, the policy on that **motor vehicle**.
- FOURTH—** For a person who is not the occupant of a **motor vehicle**, the policy on any **motor vehicle** involved in the accident.

No duplication of benefits; other insurance

In any occurrence where other similar auto insurance or self-insurance of equal priority to that provided in this coverage is available and the claim is first presented to **us, we** will process and pay the claim as if wholly responsible up to the limits of **our** policy. The total limits available from all such insurance will be considered not to exceed the highest limits available from any one source of coverage.

In no instance may an **insured** or legal representative recover duplicate benefits from the same elements of loss under this and other similar auto insurance or self-insurance.

Workers' compensation reduction

There is no coverage for **bodily injury** occurring during the course and scope of employment if workers' compensation benefits are payable or available for the **bodily injury**. Any amount payable to anyone under this coverage will only be in excess of and not in duplication of any valid and collectible workers' compensation benefit.

Insured persons' duties

The **insured**, or someone on the **insured's** behalf, will report any accident to **us** in writing as soon as practicable. This report will identify the injured and give reasonably obtainable information about the time, place and circumstances of the accident.

As soon as practicable, the **insured** or someone on the **insured's** behalf will submit written proof of claim to **us**, under oath if required. This proof will include detailed information about the nature and extent of **bodily injury**, treatment and rehabilitation received and contemplated, and anything else that may help **us** determine what benefits are payable in what amounts.

The injured person must grant **us** authorization, if **we** request it, to obtain copies of medical, income and income tax reports and records.

Injured persons must submit to examinations by company-selected physicians as often as **the company** reasonably requires. The injured person must submit to examination under oath as often as reasonably requested by **us**.

**Uninsured motorists — bodily injury****Additional definitions applicable to this coverage**

“Uninsured motor vehicle” — See definition in Coverage agreement section.

Coverage agreement***You and a relative***

We will pay compensatory damages, including derivative claims, which are due by law to **you** or a **relative** from the owner or driver of an **uninsured motor vehicle** because of **bodily injury** suffered by **you** or a **relative**. Damages must result from an accident arising out of the:

1. ownership;
2. maintenance; or
3. use;

of the **uninsured motor vehicle**.

Coverage for **you** or a **relative** under this policy also extends to replacement automobiles and to newly acquired automobiles. If, however, the newly acquired automobile does not replace **your auto**, **you** must report the acquisition of the vehicle to **us** for this extension of coverage to apply.

Other persons

We will also pay compensatory damages, including derivative claims, which are due by law to other persons from the owner or driver of an **uninsured motor vehicle** because of **bodily injury** suffered while **occupying**:

1. **Your auto.**
2. A **motor vehicle you** do not own, while it is used as a temporary substitute for **your auto**. **Your auto** must be out of use because of:
 - a) breakdown;
 - b) repair;
 - c) servicing; or
 - d) loss.

Recovery

1. Before recovery, **we** and any injured party seeking protection under this coverage must agree on two points:
 - a) whether there is a legal right to recover damages from the owner or driver of an **uninsured motor vehicle**; and if so,
 - b) the amount of such damages.
2. Any judgment against the uninsured will be binding on **us** only if it has **our** written consent.
3. The injured party shall provide notice of an uninsured motorist claim within two years after the date of the accident. If the injured party fails to provide such notice, and this failure precludes **our** ability to subrogate against liable parties, coverage may be denied as provided in Insured persons' duties No. 2 below.
4. Where multiple policies apply, payment shall be made in the following order of priority:
 - a) a policy covering a **motor vehicle** occupied by the injured person at the time of the accident.
 - b) a policy covering a **motor vehicle** not involved in the accident with respect to which the injured person is an **insured**.
5. Where multiple sources of equal priority apply, the **insured** against whom a claim is asserted first under the priorities set forth in 4. above shall process and pay the claim as if wholly responsible. **We** are thereafter entitled to recover contribution pro rata from the other insurer for the benefits paid and the cost of processing the claim.

**Definition**1. An **uninsured motor vehicle** is:

- a) one for which there is no bodily injury liability bond or insurance at the time of the accident.
- b) one for which the insuring company denies coverage or becomes insolvent.
- c) an unidentified **motor vehicle** which causes **bodily injury** to an **insured** by physical contact with:
 - (1) such **insured**; or
 - (2) a vehicle the **insured** is **occupying**.

The driver and the owner of the unidentified vehicle must be unknown. A report must be made to the police within 24 hours and us within 30 days, or as soon as practicable. It must state that the insured has a legal action due to the accident. It must include facts to support the action. We may inspect any vehicle the insured was occupying.

2. **We** will not consider as an **uninsured motor vehicle**:

- a) a **motor vehicle** for which there is liability insurance or self-insurance applicable at the time of the accident;
- b) any vehicle in use as a residence or premises;
- c) any equipment or vehicle designed for use mainly off public roads;
- d) any **motor vehicle** insured under the Auto liability coverage of this policy; nor
- e) any **motor vehicle** furnished for the regular use of **you**, a resident, or a **relative**.

Coverage exclusions

This coverage does not apply to:

1. Any **motor vehicle** while used:

- a) to carry persons or property for a fee or compensation; or
- b) on a regular basis for retail or wholesale delivery, including but not limited to pizza, magazine, newspaper and mail delivery.

Exclusion 1.a) does not apply to **motor vehicles** used in shared-expense car pools.

2. Any **motor vehicle** which any **insured**:

- a) uses without a reasonable belief of being entitled to do so;
- b) has stolen; or
- c) knows to have been stolen.

An **insured** shall not be held to have a reasonable belief of being entitled to operate a **motor vehicle** if that person's license has been suspended, revoked, or never issued.

This exclusion does not apply to the use of **your auto** by:

- a) **you**;
- b) a **relative**; or
- c) a business partner, employee, or agent of **you** or a **relative**.

3. Any of the following:

- a) judgments;
- b) costs;
- c) attorneys fees; or
- d) claims;

for punitive or exemplary damages.

4. Directly or indirectly benefit any insurer or self-insurer under any disability benefits, or similar law with the exception of a workers' compensation law.



5. **Bodily injury** suffered while **occupying** a **motor vehicle** owned by **you** or a **relative** but not insured for Uninsured motorists coverage under this policy; nor to **bodily injury** from being hit by any such **motor vehicle**.
6. **Non-economic loss** of any **insured** who has elected or has deemed to have elected "Limited Tort" in accordance with the Pennsylvania Motor Vehicle Financial Responsibility Law.
7. **Bodily injury** of any **insured** if the **insured** settles, without **our** written consent, with a liable party.
8. **Bodily injury** suffered while **occupying** a **motor vehicle**:
 - a) while used in an organized or prearranged competitive event, including but not limited to:
 - (1) racing contest or event; or
 - (2) speed contest or event; or
 - (3) in practice or preparation for any racing or speed contest or event.
 - b) while used in **performance testing** that is done on a closed road, or a race track, or a testing facility environment where the **insured** is not competing.

Performance testing is when an **insured** uses any **motor vehicle** to:

 - (1) test its performance in speed, handling; or
 - (2) test or practice driver skills.

Performance testing does not apply to student-driver training activities an **insured** participates in to obtain that person's state issued learners permit or drivers license. **Performance testing** also does not apply to driver training activities an **insured** participates in to complete that person's state sanctioned courses in motor vehicle accident prevention, defensive driving, or driver improvement.
9. **Bodily injury** arising directly or indirectly from the inhalation of, ingestion of, contact with, exposure to, existence of or presence of any fungi, algae, lichens, slime, mold, bacteria, wet or dry rot and any scents or by-products of these organisms, however produced. Fungi as used above include, but are not limited to any type or form of fungus, yeasts, mold, mildew, mycotoxins, spores, rust, smuts or fleshy fungi such as mushrooms, puffballs and coral fungi.
10. **Bodily injury** suffered while **occupying** a **motor vehicle**:
 - a) owned by;
 - b) furnished to; or
 - c) available for the regular use of;

you or a **relative**, but not insured for Auto liability coverage under this policy. It also does not apply to **bodily injury** from being hit by any such **motor vehicle**.
11. **Bodily injury** suffered while engaged in the transportation or exchange of any illegal substance, or in connection with any criminal trade or transaction. This exclusion applies to the operator or occupant of a **motor vehicle** so involved, and also to an **insured** so engaged as a pedestrian.

Insured persons' duties

1. The **insured** must:
 - a) submit written proof of the claim to **us** as soon as practicable. It must be under oath, if required. It must include details of:
 - (1) the nature and extent of injuries;
 - (2) treatment; and
 - (3) any other facts which could affect the amount of payment.
 - b) provide all facts of the accident and the names of all witnesses.



- c) submit to oral examinations under oath as often as **we** require with good reason.
- d) sign an authorization giving **us** access to the **insured's** first party medical file.
- e) be examined by doctors, including doctors examining the **insured** for rehabilitation purposes, vocational specialists, dentists or other health care providers chosen by **us** as often as **we** require with good reason. Expenses incurred at **our** request will be paid by **us**. At **our** request, the injured person or such person's legal representative must promptly authorize **us** to:
 - (1) speak with any doctor, dentist, or other health care provider who has provided treatment;
 - (2) read all medical history and reports of the injury;
 - (3) obtain copies of wage and medical reports and records;
 - (4) obtain copies of all medical, dental, and other health care bills as they are incurred; and
 - (5) speak with any employer regarding a wage loss claim.

Failure to do the above precludes recovery under this coverage.

- 2. **We** require the **insured** to file suit against any and all liable parties to preserve and protect **our** subrogation rights. Failure to do so precludes recovery under this coverage.
- 3. Where an **insured** brings legal action against another party for **bodily injury**, copies of any legal papers served in such action must be sent to **us** at once.
- 4. The **insured** must:
 - a) obtain **our** written consent to:
 - (1) settle any legal action brought against any liable party; or
 - (2) release any liable party.
 - b) preserve and protect **our** right to subrogate against any liable party.

Failure to do the above precludes recovery under this coverage.

Our right to recovery

This applies to the extent of any payment **we** make under this coverage.

- 1. **We** will have first right to any amount the **insured** receives from any liable party. The **insured** must:
 - a) hold in trust for **us** his right to recover against any such party;
 - b) do whatever is proper to secure such rights, and do nothing to prejudice them;
 - c) furnish **us** all papers in any suit the **insured** files;
 - d) do whatever is necessary to recover for **us** payments **we** have made under this coverage; and
 - e) repay **us** out of any recovery for any payments **we** have made and any expenses **we** have incurred in the action.
- 2. **Our** payment of a claim may result from the insolvency of an insurer. If so, **we** have the right to recover from the insurer, but not its insured.

Limits and conditions of payment

Amounts payable for uninsured motorists—bodily injury losses

Our obligation to pay Uninsured motorists—bodily injury losses is limited to the amounts per person and per occurrence stated in the policy Declarations. The following conditions apply to these limits:

- 1. The limit shown:
 - a) for Uninsured motorists—bodily injury for any one person is for all covered damages, including all derivative claims, claimed by anyone arising out of and due to **bodily**



injury to one person as a result of one occurrence.

The per-person limit is the total amount available when one person sustains **bodily injury**, including death, as a result of one occurrence. No separate limits are available to anyone for derivative claims, statutory claims, or any other claims made by anyone arising out of **bodily injury**, including death, to one person as a result of one occurrence.

- b) for **bodily injury** for each occurrence is the total limit of **our** liability for all covered damages when two or more persons sustain **bodily injury**, including death, as a result of one occurrence. No separate limits are available to anyone for derivative claims, statutory claims, or any other claims arising out of **bodily injury**, including death, to two or more persons as a result of one occurrence. This total limit is subject to the limit for any one person.
- 2. Coverage applies as stated in the Declarations. The insuring of more than one person or vehicle under this policy does not increase **our** Uninsured motorists payment limits. In no event will any **insured** be entitled to more than the highest per-person limit applicable to any one **motor vehicle** under this policy or any other policy issued by **us**. However, if **your** Declarations show **you** have elected "Uninsured motorists—bodily injury Stacked" coverage, the sum of limits for **your autos** apply to **you** or a **relative** as stated in the Declarations.
- 3. The limit of liability under this coverage is reduced by any amount paid to the same person for the same accident under the Auto liability coverage of this policy.
- 4. **You** must comply with the terms of the policy before **you** may sue **us**. Suit filed against **us** must be brought in the county and state where the **insured** lived at the time of the accident. In the event of a judgment against **us** for Uninsured motorist benefits, including any award for Pa. R.C.P. No 238 delay damages, the **insured** cannot recover more than the applicable per person limit provided by the policy.

Other insurance

- 1. If there is other insurance for **bodily injury** suffered by an **insured** while **occupying** a **motor vehicle** other than **your auto**, **our** coverage is excess over any other collectible:
 - a) insurance;
 - b) self insurance;
 - c) proceeds from a governmental entity;
 - d) sources of recovery other than workers' compensation benefits.
- 2. Except as stated above, if there is other insurance similar to this coverage under any other policy, **we** will be liable for only **our** share of the loss. **Our** share is **our** proportion of the total insurance limits for the loss.
- 3. If more than one policy applies, the total limits applicable will be considered not to exceed the highest limit amount of any one of them.
- 4. When the Declarations show **you** have elected "Uninsured motorists—bodily injury Stacked" coverage, the total limits applicable will be considered not to exceed the highest limit amount of any one of them for an **insured** other than **you** or a **relative**.

Duplicate payment

We will make no duplicate payment to or for any **insured** for the same element of loss.

**Underinsured motorists—bodily injury****Additional definition applicable to this coverage**

“Underinsured motor vehicle” — See definition in Coverage agreement section.

Coverage agreement***You and a relative***

We will pay compensatory damages, including derivative claims, which are due by law to **you** or a **relative** from the owner or driver of an **underinsured motor vehicle** because of **bodily injury** suffered by **you** or a **relative**. Damages must result from an accident arising out of the:

1. ownership;
2. maintenance; or
3. use;

of the **underinsured motor vehicle**.

Coverage for **you** or a **relative** under this policy also extends to replacement automobiles and to newly acquired automobiles. If, however, the newly acquired automobile does not replace **your auto**, **you** must report the acquisition of the vehicle to **us** for this extension of coverage to apply.

Other persons

We will also pay compensatory damages, including derivative claims, which are due by law to other persons from the owner or driver of an **underinsured motor vehicle** because of **bodily injury** suffered while **occupying**:

1. **Your auto**.
2. A **motor vehicle you** do not own, while it is used as a temporary substitute for **your auto**. **Your auto** must be out of use because of:
 - a) breakdown;
 - b) repair;
 - c) servicing; or
 - d) loss.

Recovery

1. Before recovery, **we** and any injured party seeking protection under this coverage must agree on two points:
 - a) whether there is a legal right to recover damages from the owner or driver of an **underinsured motor vehicle**; and if so,
 - b) the amount of such damages.
2. Any judgment against the underinsured will be binding on **us** only if it has **our** written consent.
3. The injured party shall provide notice of an underinsured motorist claim within two years after the date of the accident. If the injured party fails to provide such notice, and this failure precludes **our** ability to subrogate against liable parties, coverage may be denied as provided in Insured persons' duties No. 2 below.
4. Where multiple policies apply, payment shall be made in the following order of priority:
 - a) a policy covering a **motor vehicle** occupied by the injured person at the time of the accident.
 - b) a policy covering a **motor vehicle** not involved in the accident with respect to which the injured person is an **insured**.
5. Where multiple sources of equal priority apply, the **insured** against whom a claim is asserted first under the priorities set forth in 4. above shall process and pay the claim as if wholly responsible. **We** are thereafter entitled to recover contribution pro rata from the other insurer for the benefits paid and the cost of processing the claim.

**Definition**

1. An **underinsured motor vehicle** is a **motor vehicle** for which bodily injury liability coverage, bonds or insurance are in effect. However, their total amount is insufficient to pay the damages an **insured** is entitled to recover. **We** will pay damages that exceed such total amount.
2. **We** will not consider as an **underinsured motor vehicle**:
 - a) a **motor vehicle** for which there is sufficient liability insurance or self-insurance applicable at the time of the accident to pay losses and damages;
 - b) any vehicle in use as a residence or premises;
 - c) any equipment or vehicle designed for use mainly off public roads;
 - d) any **motor vehicle** insured under the Auto liability coverage of this policy; nor
 - e) any **motor vehicle** furnished for the regular use of **you**, a resident, or a **relative**.

Coverage exclusions

This coverage does not apply to:

1. Any **motor vehicle** while used:
 - a) to carry persons or property for a fee or compensation; or
 - b) on a regular basis for retail or wholesale delivery, including but not limited to pizza, magazine, newspaper and mail delivery.

Exclusion 1.a) does not apply to **motor vehicles** used in shared-expense car pools.

2. Any **motor vehicle** which any **insured**:
 - a) uses without a reasonable belief of being entitled to do so;
 - b) has stolen; or
 - c) knows to have been stolen.

An **insured** shall not be held to have a reasonable belief of being entitled to operate a **motor vehicle** if that person's license has been suspended, revoked, or never issued.

This exclusion does not apply to the use of **your auto** by:

- a) **you**;
- b) a **relative**; or

a business partner, employee, or agent of **you** or a **relative**.

3. Any of the following:
 - a) judgments;
 - b) costs;
 - c) attorneys fees; or
 - d) claims;for punitive or exemplary damages.
4. Directly or indirectly benefit any insurer or self-insurer under any disability benefits, or similar law with the exception of a workers' compensation law.
5. **Bodily injury** suffered while **occupying** a **motor vehicle** owned by **you** or a **relative** but not insured for Underinsured motorists coverage under this policy; nor to **bodily injury** from being hit by any such **motor vehicle**.
6. **Non-economic loss** of any **insured** who has elected or has deemed to have elected "Limited Tort" in accordance with the Pennsylvania Motor Vehicle Financial Responsibility Law.
7. **Bodily injury** of any **insured** if the **insured** settles, without **our** written consent, with a liable party.



8. **Bodily injury** suffered while **occupying** a **motor vehicle**:
- while used in an organized or prearranged competitive event, including but not limited to:
 - racing contest or event; or
 - speed contest or event; or
 - in practice or preparation for any racing or speed contest or event.
 - while used in **performance testing** that is done on a closed road, or a race track, or a testing facility environment where the **insured** is not competing.

Performance testing is when an **insured** uses any **motor vehicle** to:

- test its performance in speed, handling; or
- test or practice driver skills.

Performance testing does not apply to student-driver training activities an **insured** participates in to obtain that person's state issued learners permit or drivers license.

Performance testing also does not apply to driver training activities an **insured** participates in to complete that person's state sanctioned courses in motor vehicle accident prevention, defensive driving, or driver improvement.

9. **Bodily injury** arising directly or indirectly from the inhalation of, ingestion of, contact with, exposure to, existence of or presence of any fungi, algae, lichens, slime, mold, bacteria, wet or dry rot and any scents or by-products of these organisms, however produced. Fungi as used above include, but are not limited to any type or form of fungus, yeasts, mold, mildew, mycotoxins, spores, rust, smuts or fleshy fungi such as mushrooms, puffballs and coral fungi.
10. **Bodily injury** suffered while **occupying** a **motor vehicle**:
- owned by;
 - furnished to; or
 - available for the regular use of;

you or a **relative**, but not insured for Auto liability coverage under this policy. It also does not apply to **bodily injury** from being hit by any such **motor vehicle**.

11. **Bodily injury** suffered while engaged in the transportation or exchange of any illegal substance, or in connection with any criminal trade or transaction. This exclusion applies to the operator or occupant of a **motor vehicle** so involved, and also to an **insured** so engaged as a pedestrian.

Insured persons' duties

- The **insured** must:
 - submit written proof of the claim to **us** as soon as practicable. It must be under oath, if required. It must include details of:
 - the nature and extent of injuries;
 - treatment; and
 - any other facts which could affect the amount of payment.
 - provide all facts of the accident and the names of all witnesses.
 - submit to oral examinations under oath as often as **we** require with good reason.
 - sign an authorization giving **us** access to the **insured's** first party medical file.
 - be examined by doctors, including doctors examining the **insured** for rehabilitation purposes, vocational specialists, dentists or other health care providers chosen by **us** as often as **we** require with good reason. Expenses incurred at **our** request will be paid by **us**. At **our** request, the injured person or such person's legal representative must promptly authorize **us** to:
 - speak with any doctor, dentist, or other health care provider who has provided treatment;



- (2) read all medical history and reports of the injury;
- (3) obtain copies of wage and medical reports and records;
- (4) obtain copies of all medical, dental, and other health care bills as they are incurred; and
- (5) speak with any employer regarding a wage loss claim.

Failure to do the above precludes recovery under this coverage.

2. **We** require the **insured** to file suit against any and all liable parties to preserve and protect **our** subrogation rights. Failure to do so precludes recovery under this coverage.
3. Where an **insured** brings legal action against another party for **bodily injury**, copies of any legal papers served in such action must be sent to **us** at once.
4. The **insured** must:
 - a) obtain **our** written consent to:
 - (1) settle any legal action brought against any liable party; or
 - (2) release any liable party.
 - b) preserve and protect **our** right to subrogate against any liable party.

Failure to do the above precludes recovery under this coverage.

Our right to recovery

This applies to the extent of any payment **we** make under this coverage.

1. **We** will have first right to any amount the **insured** receives from any liable party. The **insured** must:
 - a) hold in trust for **us** his right to recover against any such party;
 - b) do whatever is proper to secure such rights, and do nothing to prejudice them;
 - c) furnish **us** all papers in any suit the **insured** files;
 - d) do whatever is necessary to recover for **us** payments **we** have made under this coverage; and
 - e) repay **us** out of any recovery for any payments **we** have made and any expenses **we** have incurred in the action.
2. **Our** payment of a claim may result from the insolvency of an insurer. If so, **we** have the right to recover from the insurer, but not its insured.

Limits and conditions of payment

Amounts payable for Underinsured motorists—bodily injury losses

Our obligation to pay Underinsured motorists—bodily injury losses is limited to the amounts per person and per occurrence stated in the policy Declarations. The following conditions apply to these limits:

1. The limit shown:
 - a) for Underinsured motorists—bodily injury for any one person is for all covered damages, including all derivative claims, claimed by anyone arising out of and due to **bodily injury** to one person as a result of one occurrence.

The per-person limit is the total amount available when one person sustains **bodily injury**, including death, as a result of one occurrence. No separate limits are available to anyone for derivative claims, statutory claims, or any other claims made by anyone arising out of **bodily injury**, including death, to one person as a result of one occurrence.
 - b) for **bodily injury** for each occurrence is the total limit of **our** liability for all covered damages when two or more persons sustain **bodily injury**, including death, as a result of one occurrence. No separate limits are available to anyone for derivative claims, statutory claims, or any other claims arising out of **bodily injury**, including death, to



two or more persons as a result of one occurrence. This total limit is subject to the limit for any one person.

2. Coverage applies as stated in the Declarations. The insuring of more than one person or vehicle under this policy does not increase **our** Underinsured motorists payment limits. In no event will any **insured** be entitled to more than the highest per-person limit applicable to any one **motor vehicle** under this policy or any other policy issued by **us**. However, if **your** Declarations show **you** have elected "Underinsured motorists—bodily injury Stacked" coverage, the sum of limits for **your autos** apply to **you** or a **relative** as stated in the Declarations.
3. The limit of liability under this coverage is reduced by any amount paid to the same person for the same accident under the Auto liability coverage of this policy.
4. No payment will be made until the limits of all other bodily injury liability insurance and bonds that apply have been exhausted by payments or judgments.
5. An **insured** who recovers damages for an uninsured motorists claim cannot recover damages for an underinsured motorists claim for the same accident.
6. **You** must comply with the terms of the policy before **you** may sue **us**. Suit filed against **us** must be brought in the county and state where the **insured** lived at the time of the accident. In the event of a judgment against **us** for Underinsured motorist benefits, including any award for Pa. R.C.P. No 238 delay damages, the **insured** cannot recover more than the applicable per person limit provided by the policy.

Other insurance

1. If there is other insurance for **bodily injury** suffered by an **insured** while **occupying** a **motor vehicle** other than **your auto**, **our** coverage is excess over any other collectible:
 - a) insurance;
 - b) self insurance;
 - c) proceeds from a governmental entity;
 - d) sources of recovery other than workers' compensation benefits.
2. Except as stated above, if there is other insurance similar to this coverage under any other policy, **we** will be liable for only **our** share of the loss. **Our** share is **our** proportion of the total insurance limits for the loss.
3. If more than one policy applies, the total limits applicable will be considered not to exceed the highest limit amount of any one of them.
4. When the Declarations show you have elected "Underinsured motorists—bodily injury Stacked" coverage, the total limits applicable will be considered not to exceed the highest limit amount of any one of them for an **insured** other than **you** or a **relative**.

Duplicate payment

We will make no duplicate payment to or for any **insured** for the same element of loss.



ADJUSTMENT

Draft Copy

Pennsylvania

Receive Date : 02/03/2016
Service Provider : **HAMMOND, JOJO D**
 20-3399558
 2601 HOLMES AVE
 PHILADELPHIA PA 19152

Claim Number : 313055-GC
Adjuster : cobbk1 - Kristen Cobb
Date Of Loss : 11/02/2015

Billing Provider : **EMERG CARE SERV OF PA PC**
 20-3399558
 PO BOX 635111
 CINCINNATI OH 45263

Patient : **BYFIELD, HERMINE**
 9200 BUSTLETON AVE APT 405
 PHILADELPHIA PA 19115

Patient Account # : 158814740/127
Carrier : **NATIONWIDE PROPERTY & CASUALTY**
INSURANCE COMPANY
 PO BOX 26005
 DAPHNE AL 36526

Dates Of Service : 11/02/2015 to 11/02/2015

LINE	DOS	PROC. CODE	MOD	DESCRIPTION	UNITS	CHARGE	*PEN REDUCTION	PROVIDER REIMBURSE	EXPLANATION
2	11/02/15	99284	*RECON* 1	Emergency department visit high/urgent severity	1	900.00	0.00	0.00	BFH
ICD Ref		1,2							
Total Lines :						900.00	0.00	0.00	

If you have any questions regarding payment, please contact your insurance carrier.

If you have question regarding this Explanation of Review, please contact our Customer Service Department at 877-444-8763.

PO BOX 26005, DAPHNE, AL 36526
 877.444.8763

Claim Number	--	Case 2:18-cv-00243-GJP Document 57-13 Filed 12/14/21 Page 27 of 48	Total Charges	--	\$ 900.00
Billing Provider	--	EMERG CARE SERV OF PA PC	Total Reimbursement	--	\$ 0.00
Service Provider	--	HAMMOND, JOJO D	Dates Of Service	--	11/02/2015 - 11/02/2015
Patient Name	--	BYFIELD, HERMINE			

Reimbursement Amount :	0.00
Less Previous Reimbursement :	0.00
Net Reimbursement Amount :	0.00
Apportionment % :	
Subtotal :	0.00
Less Deductible :	0.00
Limited Benefits/Copay :	0.00
Collateral Source/Healthcare Carrier Payment :	0.00
Plus Interest :	0.00
EOR Check Amount :	0.00
Allocated PIP Payment :	0.00
Allocated MedPay/Medical Expense Payment :	0.00

Reconsideration

LINE NUMBER	ADJUSTS	EXPLANATION	DESCRIPTION
2	1	BFH	The benefits for this patient/claim are exhausted.

Explanation summarys

EXPLANATION	EXPLANATION FOR THE REIMBURSEMENT AMOUNT	REF DOC_ID	REF LINE NUMBER
BFH	The benefits for this patient/claim are exhausted.		

If you have any questions regarding payment, please contact your insurance carrier.

If you have question regarding this Explanation of Review, please contact our Customer Service Department at 877-444-8763.

Claim Number	--	Case 2:18-cv-00243-GJP Document 57-13 Filed 12/14/21 Page 28 of 48	Total Charges	--	\$ 900.00	11/24/2015-Adj -we
Billing Provider	--	EMERG CARE SERV OF PA PC	Total Reimbursement	--	\$ 0.00	
Service Provider	--	HAMMOND, JOJO D	Dates Of Service	--	11/02/2015 - 11/02/2015	
Patient Name	--	BYFIELD, HERMINE				

Comments :
No comments

If you have any questions regarding payment, please contact your insurance carrier.
 If you have question regarding this Explanation of Review, please contact our Customer Service Department at 877-444-8763.

Claim Number	--	913055-08	Total Charges	--	\$ 900.00
Billing Provider	--	EMERG CARE SERV OF PA PC	Total Reimbursement	--	\$ 0.00
Service Provider	--	HAMMOND, JOJO D	Dates Of Service	--	11/02/2015 - 11/02/2015
Patient Name	--	BYFIELD, HERMINE			

"If payment is due, check will be mailed under separate cover. Cashing this check will not forfeit your appeal rights. The amount shown should be considered full payment for service dates indicated, unless additional information is requested. The submitted claim, resulting in this explanation of review, reimbursement or benefit, was processed in accordance with AUTOMOBILE INSURANCE MEDICAL COST CONTAINMENT, PROVIDER BILLING act, 31 Pa. Code Sections 69.21 – 69.26. Warning: Pursuant to 18 Pa. C.S. §4117(k)(1), "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties." APPEAL PROCESS: Please submit the following to the address listed below: 1. A copy of this Explanation of Reimbursement , 2. The reasons that you disagree with the reimbursement, 3. A copy of all supporting medical documentation concerning this appeal."

If you have any questions regarding payment, please contact your insurance carrier.
 If you have question regarding this Explanation of Review, please contact our Customer Service Department at 877-444-8763.

PO BOX 26005, DAPHNE, AL 36526
 877.444.8763



On Your Side®

Pennsylvania

EXPLANATION OF REVIEW

Archive Copy

Receive Date : 02/03/2016
Service Provider : **HAMMOND, JOJO D**
 20-3399558
 2601 HOLMES AVE
 PHILADELPHIA PA 19152

Claim Number : 313055-GC
Adjuster : cobbk1 - Kristen Cobb
Date Of Loss : 11/02/2015

Billing Provider : **EMERG CARE SERV OF PA PC**
 20-3399558
 PO BOX 635111
 CINCINNATI OH 45263

Patient : **BYFIELD, HERMINE**
 9200 BUSTLETON AVE APT 405
 PHILADELPHIA PA 19115

Provider Title : MD
Provider Specialty : Unknown Specialty

Patient Account # : 158814740/127
Carrier : **NATIONWIDE PROPERTY & CASUALTY
 INSURANCE COMPANY**
 PO BOX 26005
 DAPHNE AL 36526

Dates Of Service : 11/02/2015 to 11/02/2015

ICD REF	ICD	POA	IND	DIAGNOSIS DESCRIPTION					
1	S39.012A		ICD-0	Strain musc fasc tendon lw back int					
2	S29.002A		ICD-0	Uns inj msc tend back wall th init					

LINE	DOS	PROC CODE	MOD	DESCRIPTION	UNITS	CHARGE	*PEN REDUCTION	PROVIDER REIMBURSE	EXPLANATION
1	11/02/15	99284		Emergency department visit high/urgent severity	1	900.00	0.00	0.00	DOC55
ICD Ref		1,2							
Total Lines :		1				900.00	0.00	0.00	

If you have any questions regarding payment, please contact your insurance carrier.

If you have question regarding this Explanation of Review, please contact our Customer Service Department at 877-444-8763.

PO BOX 26005, DAPHNE, AL 36526
 877.444.8763

Claim Number --	313055-GC	Total Charges --	\$ 900.00	NM2429947-EOBID -db
				Archive Copy
Billing Provider --	EMERG CARE SERV OF PA PC	Total Reimbursement --	\$ 0.00	
Service Provider --	HAMMOND, JOJO D			
Patient Name --	BYFIELD, HERMINE	Dates Of Service --	11/02/2015 - 11/02/2015	

Reimbursement Amount :	0.00
Apportionment % :	
Subtotal :	0.00
Less Deductible :	0.00
Limited Benefits/Copay :	0.00
Collateral Source/Healthcare Carrier Payment :	0.00
Plus Interest :	0.00
EOR Check Amount :	0.00
Allocated PIP Payment :	0.00
Allocated MedPay/Medical Expense Payment :	0.00

EXPLANATION	EXPLANATION FOR THE REVIEW AMOUNT	REF DOC_ID	REF LINE NUMBER
DOC55	In order to make a reimbursement decision, documentation is needed to support the medical necessity for continued care or treatment. Documentation must include all records, such as patient history, evaluations, test results, progress notes, prescriptions and treatment plans.		

If you have any questions regarding payment, please contact your insurance carrier.

If you have question regarding this Explanation of Review, please contact our Customer Service Department at 877-444-8763.

PO BOX 26005, DAPHNE, AL 36526
877.444.8763

Claim Number	--	313055-GC	Total Charges	--	\$ 900.00	NM2429947- EOBID -db
Billing Provider	--	EMERG CARE SERV OF PA PC				Archive Copy
Service Provider	--	HAMMOND, JOJO D	Total Reimbursement	--	\$ 0.00	
Patient Name	--	BYFIELD, HERMINE	Dates Of Service	--	11/02/2015 - 11/02/2015	

Comments :No comments

If you have any questions regarding payment, please contact your insurance carrier.

If you have question regarding this Explanation of Review, please contact our Customer Service Department at 877-444-8763.

PO BOX 26005, DAPHNE, AL 36526
877.444.8763

Printed On --

05-Feb-2016 11:13 am

Page 3 of 4

Claim Number --	313055-GC	Total Charges --	\$ 900.00	NM2429947- EOBID -db
				Archive Copy
Billing Provider --	EMERG CARE SERV OF PA PC	Total Reimbursement --	\$ 0.00	
Service Provider --	HAMMOND, JOJO D			
Patient Name --	BYFIELD, HERMINE	Dates Of Service --	11/02/2015 - 11/02/2015	

"If payment is due, check will be mailed under separate cover. Cashing this check will not forfeit your appeal rights. The amount shown should be considered full payment for service dates indicated, unless additional information is requested. The submitted claim, resulting in this explanation of review, reimbursement or benefit, was processed in accordance with AUTOMOBILE INSURANCE MEDICAL COST CONTAINMENT, PROVIDER BILLING act, 31 Pa. Code Sections 69.21 – 69.26. Warning: Pursuant to 18 Pa. C.S. §4117(k)(1), "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties." APPEAL PROCESS: Please submit the following to the address listed below: 1. A copy of this Explanation of Reimbursement , 2. The reasons that you disagree with the reimbursement, 3. A copy of all supporting medical documentation concerning this appeal."

If you have any questions regarding payment, please contact your insurance carrier.

If you have question regarding this Explanation of Review, please contact our Customer Service Department at 877-444-8763.

PO BOX 26005, DAPHNE, AL 36526
877.444.8763



Documentation Request - 2nd Notice

This is not a bill

Archive Copy

Provider Copy

Pennsylvania
Company : 0009 - NATIONWIDE PROP

Receive Date : 02/03/2016
Service Provider : HAMMOND, JOJO D
20-3399558 2601 HOLMES AVE
PHILADELPHIA PA 19152

Claim Number : 313055-GC

Adjuster : cobbk1 - Kristen Cobb

Date Of Loss : 11/02/2015

Customer Service : 877-444-8763

Patient : BYFIELD, HERMINE
9200 BUSTLETON AVE APT 405
PHILADELPHIA PA 19115

Billing Provider : EMERG CARE SERV OF PA PC
PO BOX 635111
CINCINNATI OH 45263

Patient Account # : 158814740/127

Dates Of Service : 11/02/2015 to 11/02/2015

March 2, 2016

Dear Sir or Madam:

We have received medical billing for the patient and dates of service indicated below. In order to properly review one or more procedures on this bill, we need additional supporting documentation. Please review the information below, which indicates the procedures in question and the documentation requested.

Please resubmit the requested material and a copy of this form to the following address:

NATIONWIDE INS - AFFILIATED CO
ALLIED INS - AFFILIATED CO
TITAN INS - AFFILIATED CO
PO BOX 26005
DAPHNE, AL 36526

Should you have any questions, please contact Auto Injury Solutions on behalf of Nationwide at 877-444-8763 and reference document id NM2429947.

cobbk1 - Kristen Cobb



Claim Number : 313055-GC

NM2429947- InfoReq -rp

Archive Copy

Billing Provider : EMERG CARE SERV OF PA PC

Service Provider : HAMMOND, JOJO D

Total Charges : 0.00

Patient Name : BYFIELD, HERMINE

Dates Of Service : 11/02/2015 - 11/02/2015

ICD - 9 DIAGNOSIS DESCRIPTION

S39.012A ICD-0 - Strain musc fasc tendon lw back int

S29.002A ICD-0 - Uns inj msc tend back wall th init

LINE	DATE OF NR SERVICE	CPT CODE	MOD	DESCRIPTION	UNITS	BILLED AMOUNT	PPO REDUCTION	REIM AMOUNT	REASON CODE
1	11/2/15	99284		Emergency department visit high/urgent severity	1	900.00	0.00	0.00	DOC55
Total Lines :						0.00	0.00	0.00	

Comments : In order to make a reimbursement decision, documentation is needed to support the medical necessity for continued care or treatment. Documentation must include all records, such as patient history, evaluations, test results, progress notes, prescriptions and treatment plans.

EXPLANATION	EXPLANATION FOR THE REVIEW AMOUNT	REF DOC_ID	REF LINE NUMBER
DOC55	In order to make a reimbursement decision, documentation is needed to support the medical necessity for continued care or treatment. Documentation must include all records, such as patient history, evaluations, test results, progress notes, prescriptions and treatment plans.		

"If payment is due, check will be mailed under separate cover. Cashing this check will not forfeit your appeal rights. The amount shown should be considered full payment for service dates indicated, unless additional information is requested. The submitted claim, resulting in this explanation of review, reimbursement or benefit, was processed in accordance with AUTOMOBILE INSURANCE MEDICAL COST CONTAINMENT, PROVIDER BILLING act, 31 Pa. Code Sections 69.21 – 69.26. Warning: Pursuant to 18 Pa. C.S. §4117(k)(1), "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties." APPEAL PROCESS: Please submit the following to the address listed below: 1. A copy of this Explanation of Reimbursement , 2. The reasons that you disagree with the reimbursement, 3. A copy of all supporting medical documentation concerning this appeal."

cobbk1 - Kristen Cobb



Claim Number : 313055-GC

NM2429947- InfoReq -rp

Archive Copy

Billing Provider : EMERG CARE SERV OF PA PC

Service Provider : HAMMOND, JOJO D

Total Charges : 0.00

Patient Name : BYFIELD, HERMINE

Dates Of Service : 11/02/2015 - 11/02/2015

If you have question regarding this Explanation of Review, please contact our Customer Service Department at 877-444-8763.

Please send all requested information to the following address:

NATIONWIDE INS - AFFILIATED CO
ALLIED INS - AFFILIATED CO
TITAN INS - AFFILIATED CO
PO BOX 26005
DAPHNE, AL 36526

cobbk1 - Kristen Cobb



Documentation Request - 3rd Notice

This is not a bill

Archive Copy

Provider Copy

Pennsylvania
Company : 0009 - NATIONWIDE PROP

Receive Date : 02/03/2016
Service Provider : HAMMOND, JOJO D
20-3399558 2601 HOLMES AVE
PHILADELPHIA PA 19152

Claim Number : 313055-GC

Adjuster : cobbk1 - Kristen Cobb

Date Of Loss : 11/02/2015

Customer Service : 877-444-8763

Patient : BYFIELD, HERMINE
9200 BUSTLETON AVE APT 405
PHILADELPHIA PA 19115

Billing Provider : EMERG CARE SERV OF PA PC
PO BOX 635111
CINCINNATI OH 45263

Patient Account # : 158814740/127

Dates Of Service : 11/02/2015 to 11/02/2015

April 1, 2016

Dear Sir or Madam:

We have received medical billing for the patient and dates of service indicated below. In order to properly review one or more procedures on this bill, we need additional supporting documentation. Please review the information below, which indicates the procedures in question and the documentation requested.

Please resubmit the requested material and a copy of this form to the following address:

NATIONWIDE INS - AFFILIATED CO
ALLIED INS - AFFILIATED CO
TITAN INS - AFFILIATED CO
PO BOX 26005
DAPHNE, AL 36526

Should you have any questions, please contact Auto Injury Solutions on behalf of Nationwide at 877-444-8763 and reference document id NM2429947.

cobbk1 - Kristen Cobb



Claim Number : 313055-GC

NM2429947- InfoReq -rp

Archive Copy

Billing Provider : EMERG CARE SERV OF PA PC

Service Provider : HAMMOND, JOJO D

Total Charges : 0.00

Patient Name : BYFIELD, HERMINE

Dates Of Service : 11/02/2015 - 11/02/2015

ICD - 9 DIAGNOSIS DESCRIPTION

S39.012A ICD-0 - Strain musc fasc tendon lw back int

S29.002A ICD-0 - Uns inj msc tend back wall th init

LINE	DATE OF NR SERVICE	CPT CODE	MOD	DESCRIPTION	UNITS	BILLED AMOUNT	PPO REDUCTION	REIM AMOUNT	REASON CODE
1	11/2/15	99284		Emergency department visit high/urgent severity	1	900.00	0.00	0.00	DOC55
Total Lines : 1						0.00	0.00	0.00	

Comments : In order to make a reimbursement decision, documentation is needed to support the medical necessity for continued care or treatment. Documentation must include all records, such as patient history, evaluations, test results, progress notes, prescriptions and treatment plans.

EXPLANATION	EXPLANATION FOR THE REVIEW AMOUNT	REF DOC_ID	REF LINE NUMBER
DOC55	In order to make a reimbursement decision, documentation is needed to support the medical necessity for continued care or treatment. Documentation must include all records, such as patient history, evaluations, test results, progress notes, prescriptions and treatment plans.		

"If payment is due, check will be mailed under separate cover. Cashing this check will not forfeit your appeal rights. The amount shown should be considered full payment for service dates indicated, unless additional information is requested. The submitted claim, resulting in this explanation of review, reimbursement or benefit, was processed in accordance with AUTOMOBILE INSURANCE MEDICAL COST CONTAINMENT, PROVIDER BILLING act, 31 Pa. Code Sections 69.21 – 69.26. Warning: Pursuant to 18 Pa. C.S. §4117(k)(1), "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties." APPEAL PROCESS: Please submit the following to the address listed below: 1. A copy of this Explanation of Reimbursement , 2. The reasons that you disagree with the reimbursement, 3. A copy of all supporting medical documentation concerning this appeal."

cobbk1 - Kristen Cobb



Claim Number : 313055-GC

NM2429947- InfoReq -rp

Archive Copy

Billing Provider : EMERG CARE SERV OF PA PC**Service Provider :** HAMMOND, JOJO D**Total Charges :** 0.00**Patient Name :** BYFIELD, HERMINE**Dates Of Service :** 11/02/2015 - 11/02/2015

If you have question regarding this Explanation of Review, please contact our Customer Service Department at 877-444-8763.

Please send all requested information to the following address:

NATIONWIDE INS - AFFILIATED CO
ALLIED INS - AFFILIATED CO
TITAN INS - AFFILIATED CO
PO BOX 26005
DAPHNE, AL 36526

cobbk1 - Kristen Cobb



Hermine Byfield

Page 1 of 1

Date prepared February 5, 2016
Claim number 313055-GC

Questions? Contact Claims Associate
Kristen Cobb
COBBK1@nationwide.com
Phone 717-657-6604

Hermine Byfield
9200 Bustleton Ave Apt 405
Philadelphia, PA 19115-4218

Benefit limit has been reached

Dear Ms. Byfield,

We've reviewed this Medical Benefits claim and determined the benefit limit has been reached. This means we've paid the maximum amount allowed by your policy.

Claim details

Insurer:	Nationwide Property & Casualty Insurance Company
Policyholder:	Hermine Byfield
Claimant:	Hermine Byfield
Claim number:	313055-GC
Loss date:	November 2, 2015

Keep in mind

You may be responsible for any outstanding expenses related to this claim. We strongly suggest you explore other available options for covering additional expenses.

For help when you need it

If you have any questions or concerns about your claim, please contact me at 717-657-6604 or COBBK1@nationwide.com.

Sincerely,

Kristen Cobb
Nationwide Property & Casualty Insurance Company
PO Box 26005
Daphne, AL 36526-5005

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.



Hermine Byfield

Page 1 of 2

Date prepared November 12, 2015

Claim number 313055-GC

Questions? Contact Claims Associate
Dawn Graves
GRAVED2@nationwide.com
Phone 717-657-6766

Hermine Byfield
9200 Bustleton Ave Apt 405
Philadelphia, PA 19115-4218

How to file a claim for medical expenses

Dear Mr. Byfield,

Under your First Party Benefits, we may be able to help pay for your accident-related medical expenses and lost wages. If you decide to file a claim, please follow the steps outlined below.

Claim details

Insurer:	NATIONWIDE PROPERTY & CASUALTY INSURANCE COMPANY
Policyholder:	Hermine Byfield
Claimant:	Hermine Byfield
Claim number:	313055-GC
Loss date:	November 2, 2015

Policy details

This auto policy provides First Party Benefits as listed below:

1. Medical Benefits: \$5000.00
- *2. Income Loss Benefits: \$000.00
Monthly Maximum: \$000.00
3. Accidental Death Benefits: \$000.00
4. Funeral Benefits: \$2500.00
5. Combined Loss Benefits: \$000.00
(May include benefits from 1, 2, 3 and 4 above.)
(Benefits are limited to three years from the accident date.)
6. Extraordinary Medical Benefits: \$000,000,000 per year

*If you file a claim under this coverage, we'll mail a verification form to your employer. Your doctor must confirm your disability on a monthly basis. After the first five working days following your injury, wage payments will be made on a monthly basis during your disability period, up to the limit of your income loss benefits. Please notify us when you return to work.

What you need to do

Please complete and sign the enclosed forms and return them to me by mail: P.O. Box 26005, Daphne, AL 36526-5005, email:

Hermine Byfield
Page 2 of 2

GRAVED2@nationwide.com or fax: 877-590-8188 by **as soon as possible**:

- **Application for Benefits form** — We need to receive this form to evaluate your claim and/or begin paying for your medical expenses; the injured party must complete this form, if the injured party is under the age of 18, the injured party's parent or legal guardian must complete the form
- **Records Authorization form** — This form allows us to obtain medical, wage, employment and school information we need to review your claim for covered medical expenses and lost wages; this authorization only applies to the evaluation of this claim, and all information is kept confidential

Keep in mind

If you receive health care for accident-related injuries, please ask your medical providers to send bills to us at: Nationwide Insurance, P.O. Box 26005, Daphne, AL 36526-5005. Send copies of any current or future medical bills you receive to us at this same address. As part of the claims process, we review medical bills and records to ensure they're reasonable, necessary and related to the reported claim.

Additional information

Pennsylvania Auto Insurance Law, Act 6, specifically requires that:

*Medical care providers "may not bill the insured directly, but must bill the insurer for a determination of the amount payable." This applies to all providers of medical care, including pharmacies and suppliers of medical equipment.

*Medical care providers will be limited on the amount they can charge insurance companies for services related to auto accidents.

*Medical care providers may not "...bill or otherwise attempt to collect from the insured, the difference between the provider's full charge and the amount paid by the insurer."

You can always count on us to be there

We want to continue meeting your insurance needs. If you have any questions or concerns, please contact me at 717-657-6766 or GRAVED2@nationwide.com.

Sincerely,

Dawn Graves
NATIONWIDE PROPERTY & CASUALTY INSURANCE COMPANY
P.O. Box 26005
Daphne, AL 36526-5005

APPLICATION FOR BENEFITS

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS PLEASE COMPLETE THIS APPLICATION FORM AND RETURN IT PROMPTLY.

DATE: November 12, 2015

OUR POLICYHOLDER: Hermine Byfield

CLAIM NUMBER: 313055-GC

DATE OF ACCIDENT: November 2, 2015

INJURED PARTY (if other than addressee): Hermine Byfield

IMPORTANT:

1. To be eligible for benefits you must complete and sign this application.
2. You must also sign the enclosed records authorization.
3. Return promptly with copies of any bills received to date.

Phone Nos. Home:

Business:

Date of Birth:

Social Security No.:

Email Address:

Your Residence At The Time of The Accident:

Name/Address of Owner of Vehicle You Occupied/Operated:

Insurance Co. of Vehicle Owner:

Place of Accident (Street, City or Town and State):

Brief Description of Accident:

Describe Automobiles Owned By You and By Any Member of Your Family Residing In the Same Household

Automobile	Veh. ID Number	Owner	Insurer	Policy No.	License No.
Veh. 1					
Veh. 2					
Veh. 3					

As a Result of This Accident Were You Injured? ☐ Yes ☐ No

If Your Answer Is Yes, Complete The Rest of This Form. If No, Sign Here and Return This Form To Us.

SIGNATURE:

DATE:

Describe your injury:

Have you ever had the same or similar injury? ☐ Yes ☐ No

If yes, explain:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.

Initial(s): _____

Date: _____

APPLICATION FOR BENEFITS

Name of family physician: _____

Were you Treated By a Doctor or Other Person Furnishing Health Services? ☐ Yes ☐ No

Name and Address of Such a Person: _____

If You Were Treated In a Hospital, Were You: ☐ An In-patient ☐ An Out-patient

Treatment Dates: _____

Hospital's Name and Address: _____

Will you have more Health Expenses? ☐ Yes ☐ NoAt the Time of Your Accident: Did you Lose Time From Work? ☐ Yes ☐ No If Yes, How Much? _____Were You In The Course of Your Employment? ☐ Yes ☐ No

If Yes, Date Disability From Work Began: _____

Date You Returned To Work: _____

What Are Your Average Gross Weekly Earnings? \$ _____

Have You Received or Are You Eligible For Any Medical or Disability Benefits Under:

Worker's Compensation ☐ Yes ☐ NoFederal Social Security ☐ Yes ☐ NoAre you a Medicare beneficiary? ☐ Yes ☐ NoHave you applied for Medicare benefits? ☐ Yes ☐ NoAre you a Medicaid beneficiary? ☐ Yes ☐ NoHave you applied for Medicaid benefits? ☐ Yes ☐ No

ID# INFORMATION: _____

List Names and Addresses of Your Employers For One Year Prior to Accident.

Give Occupation and Dates of Employment:

Employer and Address: _____

Occupation: _____

From: _____

To: _____

Employer and Address: _____

Occupation: _____

From: _____

To: _____

As a Result of Your Injury Have You Had Any Other Expenses? ☐ Yes ☐ No

If Yes, Attach Explanation and Amounts of Such Expenses. _____

The Applicant Authorizes the Insurer to Submit Any and All of These Forms to Another Party Or Insurer If Such is Necessary to Protect Its Rights of Recovery Provided For Under This Act. We Recommend You Also Contact Your Group Or Health Insurance Carrier In the Event Your Expenses Exceed the First Party Benefits Coverage.

SIGNATURE: _____

DATE: _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.

RECORDS AUTHORIZATION

OUR INSURED: Hermine Byfield

INJURED PARTY: Hermine Byfield

OUR CLAIM NUMBER: 313055-GC

DATE OF ACCIDENT: November 2, 2015

I authorize you to furnish to NATIONWIDE PROPERTY & CASUALTY INSURANCE COMPANY or its representative, all my records concerning:

1. Hospital or medical/dental treatment, including diagnosis, prognosis, disability and service charges.
2. Earnings information, including rate of pay, job classification and loss of time from work.
3. School information, including loss of time, grades and reduced activities, if any.

I also authorize NATIONWIDE PROPERTY & CASUALTY INSURANCE COMPANY to furnish any of the above mentioned records to my group, health or accident insurance company.

A copy of this authorization may be accepted with the same authority as the original.

PATIENT'S NAME (Please Print):

PATIENT'S DATE OF BIRTH:

PATIENT'S SIGNATURE:

DATE:

IF A MINOR, SIGNATURE OF PARENT OR GUARDIAN

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.